DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/30/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		15G718	B. WING	B. WING		01/22/2015	
NAME OF PROVIDER OR SUPPLIER BENCHMARK HUMAN SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 2331 CANDLEWICK DR FORT WAYNE, IN 46804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
W 000	INITIAL COMMENTS		W	000			
	This visit was for a furecertification and sta						
	Dates of Survey: January 20, 21 and 22, 2015.						
	Facility number: 004404 Provider number: 15G718						
		0510050					
	Surveyor: Kathy Wa	nner, QIDP					
	be in compliance with and 460 IAC 9 in rega annual recertification	Services, Inc. was found to a 42 CFR, part 483, subpart I ard to the fundamental and state licensure survey. Ileted 1/29/15 by Ruth					
L ABORATORY	 DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	 F		TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.